STATE OF CONNECTICUT

INSURANCE DEPARTMENT

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Testimony of the Connecticut Insurance Department

Before the
Insurance and Real Estate Committee

March 4th, 2010

Raised Bill 258--An Act Concerning Appeals of Health Insurance Benefit Denials

Thank you for the opportunity to comment on Raised Bill 258, An Act Concerning Appeals of Health Insurance Benefit Denials. The Insurance Department believes this bill is not only unnecessary, but actually detracts from the value of and invalidates the impartiality of the external appeals process.

The current External Appeals process is promulgated on the premise that the rights of consumers to fair and medically appropriate treatment should be balanced with the responsibility of the health plan to review treatment in relation to established standards of medical care. When services are denied by the health plan, the External Appeal review entity has the ultimate responsibility to be the independent arbiter for determining medical need. This balance creates an environment where all parties share in the responsibility for making appropriate medical decisions.

This proposal makes the assumption that the denied service is medically necessary and shifts the burden of proof of medical necessity from the medical care provider to the health insurer having to disprove medical necessity. Since the statutory purpose of external appeal review by an independent entity is to provide an unbiased independent review, this shift to the insurer having to disprove medical necessity for each service rendered will prolong determination of benefits, and add additional administrative costs to the process of benefit determination. In 2009, there were 184 cases that went through the external review process. It is anticipated that this number would increase considerably should the presumption of medical necessity change, as proposed in this legislation. In addition, this will remove any sentinel effect of reducing medical care costs by removing a very important incentive to provide medical care on an efficient basis since medical providers will claim they have a presumption of medical necessity on all treatment recommendations.

The requirements that the notice of final determination include a statement that the utilization review company will provide to the provider of record and the enrollee a copy of all documents and information considered in the final determination should include a provision that the information should be provided only upon request by the provider of record or the enrollee to protect privacy rights.

Finally, the Insurance Department sees no need for the addition of the provisions dealing specifically with the denials relating to prescription drugs. This proposal essentially guts

utilization review for drugs and draws out the time frame for all appeals to a point where it could exceed more than six months to reach resolution and provides a presumption of medical appropriateness to the prescriber. This provision would result in the provider of record and enrollee having a "blank check" for any prescription drugs that they chose through the entire appeal process. This proposal does not address what to do if the drug is denied not for medical necessity, but because it is not a covered benefit or if there are copays, deductibles, waiting periods or other contractual provisions that might be the source of the denial. There are real safety concerns as well as concerns regarding the timeliness, the potentially astronomical cost of drugs that may ultimately determined to be not medically necessary and administration of such a proposal.

We respectfully request that the Committee reject this proposal.